System Leadership Council: November 1 Meeting Summary

Introduction

- The following members attended the second meeting of the System Leadership Council:

Janet Areson	Marion Greenfield	Julie A. Stanley
H. Lynn Chenault	Richard E. Kellogg	James A. Stewart, III
Charline A. Davidson	Larry L. Latham, Ph.D.	William J. Thomas
Judy Dudley	Martha J. Mead	James A. Thur
Brent Frank	Jules J. Modlinski, Ph.D.	Candace B. Waller
Paul R. Gilding	Raymond R. Ratke	

General Business

- Before discussing the topics on the agenda (attached for information purposes), a Council member noted that the summary of the first meeting did not mention the state compensation reform materials, which the Department had agreed to distribute to CSBs. Several other members commented that the material is on the Department's internet site already. The Commissioner agreed and encouraged everyone to view it there in lieu of the Department mailing out a huge stack of material. Department human resources management staff are available for consultation about this information, if a particular CSB is interested.

- The Council agreed that the first item on each meeting's agenda should be a review of the summary of the previous meeting and that it would be helpful at the end of each meeting to identify a preliminary agenda for the next meeting.

Standardization in Community Services

- Marion Greenfield, who works for Dr. James Evans, the Director of the Office of Health and Quality Care, described the Department's standardization initiative for its state facilities, which began three years ago. In fact, interest in standardization at state facilities started with Commissioner King Davis.

- While the initiative was not a response to federal Department of Justice CRIPA activities, these activities did provide an impetus to move ahead in this area. The initiative has focused on clinical rather than administrative policies and procedures.

- Senior Department managers identified the most important processes that would assure positive outcomes for consumers, rather than identifying problem processes that should be fixed. The emphasis was and continues to be on quality improvement.

- Then, the most important processes were selected for development of Departmental Instructions. Examples included active treatment planning, medications, seclusion and restraint, surrogate decision making, and clinical records.

- Each process was assigned to a small work group. The average size of most work groups was 12 members. Whenever possible, a physician was included. The Department's Central Office chose people who would support standardization to be members of the work groups.

- Work group chairmen, key Central Office staff, and a representative of the Office of the Attorney General formed a steering committee to guide the initiative. The steering committee reviewed work group products and implementation time frames. The Department also contracted for an ethicist to look at some of the products.

- Work groups developed their products, which usually took nine to twelve months, and circulated them for field reviews. A lot of the work took place through electronic communication, rather than face-to-face meetings. After the field reviews, work groups revised their products.

- The initial draft products were developed without regard to resource availability. Later modifications took into account resources, procedural efficiencies, and staffing patterns, but clinical quality remained the focus of each product.

- Central Office staff, state facility directors, and medical directors finalized the products, and most of this work was done electronically. At that point, products were issued as Departmental Instructions, which are the Department's operating policies and procedures.

- There was some initial resistence to uniform clinical procedures; but the active involvement of work group members in shaping these new procedures helped to diminish staff concerns. Work group members, especially those who were involved in Department of Justice activities, recognized the value of such procedures and served as advocates throughout the process.

- The Commissioner described the rationale for this process. Many Departmental Instructions affecting consumers were far out of date; but they still affected consumers. Rather than revise Instructions on a piecemeal basis, it made more sense to take a comprehensive approach. He also noted that the Department did this internally, without hiring expensive consultants and spending millions of dollars. He observed that some private sector people are baffled that the Department could do this without hiring consultants and spending large amounts of money.

- The results, even at this early date, have been impressive. For example, there has been a 75 percent reduction in the use of seclusion and restraint. The initiative emphasizes quality improvement, rather than taking a more punitive approach.

- In response to a comment from a Council member about implementation and follow up, it was noted that the Department obtained funds to implement an interactive training system. It was pointed out that these funds were available only for psychosocial rehabilitation and behavioral treatment and not for all initiatives. Also the Department's training resources and services have been refocused on the initiative. Finally, the Department monitors data (e.g., the 75 percent reduction noted above) to ensure that the new procedures have the intended systems impact.

- Larry Latham described how he has implemented these new Departmental Instructions at Central State Hospital. He emphasized the importance of training and suggested that the Department provide these Departmental Instructions to psychiatry, psychology, and social work schools for

them to use to train and educate students.

- The Council agreed that developing uniform clinical or care policies or protocols in some areas holds considerable promise for community services. One member expressed a concern that this not become a solution in search of a problem and suggested conducting problem assessments instead. The Commissioner reiterated that the Department consciously avoided this approach and noted that the Department was not interested in investing resources to identify problems first. He also noted that fourth generation health care policy supports use of uniform clinical or care policies and procedures.

- The Commissioner described the philosophical approach embodied in such an effort: identify the best ways to treat people for the problems that they have and then move the services system in non-punitive ways to implement those best ways, using data and standards.

- One area in which a need for uniformity was identified is how consumers move from one CSB to another. Another was the assignment of case management responsibility for residents in state mental retardation training centers.

- Some members expressed concerns about implementing anything until staffing and caseload standards are established and sufficient resources are available. However, clinical or care policies and procedures (e.g., use of seclusion and restraint) are independent of staffing policies or levels. Also, they can be developed independently of resource considerations. Uniform care or clinical policies and procedures are also an opportunity for the services system to re-examine itself and increase its treatment effectiveness.

- The Commissioner observed that, throughout the HJR 240/225 Joint Subcommittee process, the $100 million plus of existing state funds in CSB base budgets have been off the table. However, if the services system is serious about developing and implementing uniform clinical or care policies and procedures, the use and re-prioritization of existing funds must be examined.

- The Commissioner also raised concerns about the type and intensity of psychosocial rehabilitation available in many communities. He noted that he has been greatly impressed by the results of the psychosocial rehabilitation initiative in state hospitals, which has instituted very intensive consumer-focused services at those facilities, as opposed to the more traditional clubhouse approach still used in many CSBs.

- It was noted that the VACSB Executive Directors Forum supports developing uniform clinical or care policies and procedures, but this needs to be defined or focused on specific areas. The current effort by the VACSB Mental Health Council, with Department participation, was cited as an example of such efforts.

- The Commissioner noted that he is compelled to move forward with developing clinical or care uniformity in community services. He suggested that some of these issues are not too complicated (e.g., caseload standards for psychiatrists and case managers and the use of nurse clinicians). He agreed that any activities should be targeted or focused.
- **The Council agreed that initial efforts to develop and implement uniform clinical care policies and procedures should be focused on individuals with serious mental illnesses, so**

that any effort can achieve early success and build on that. The charge to the Council members is to think about quality improvement for this population before the next meeting and be prepared to make decisions then about specific initiatives.

- **The Council also agreed to address assigning case management responsibility and transferring it from one CSB to another for individuals with mental retardation. It was suggested that the process used by mental health might serve as an example.**

Psychiatry in Community Services Boards

- The Commissioner noted that he reviewed the VACSB psychiatry survey data, which led him to question whether, in a $600 million services system, community psychiatric services have been appropriately prioritized. Given the dearth of psychiatrists in the CSB system, he asked why the Department should not be telling CSBs to re-prioritize their use of existing funds to increase psychiatric services. He reflected on his experience of doing this at the two CSB where he served as executive director.

- This is even more important now, since the key to treating individuals with serious mental illnesses effectively is pharmacology. The Department is very interested in pharmacology and its relationship to psychiatry.

- A member observed that CSBs shift resources from year to year among services, especially now as state hospitals grow smaller. It was noted that some CSBs with low levels of psychiatric care decided to devote more resources to decreasing state hospital utilization. The Commissioner observed, however, that this should not be a mutually exclusive situation.

- The issue of availability of psychiatrists, particularly in rural areas was raised. Most of the CSBs in the survey with the highest consumer to psychiatrist ratios were rural CSBs. Another member suggested that caseload standards for psychiatrists would be helpful.

- In response to a question, the Commissioner indicated that, given the small amount of funds involved for most CSBs, he would consider streamlining the detailed reporting requirements associated with the new psychiatric services money.

- The Commissioner also observed that there is a need for more consistency or uniformity among CSBs regarding psychiatric services, but that just a number, such as a hypothetical 200 consumer per psychiatric FTE ratio, may be too simplistic. Multiple analyses are needed.

Jail-Based Services

- The Commissioner noted that the public is being inundated with information about this issue, and he placed it on the agenda for planning purposes. He has discussed this with the head of the sheriff's association and the Department of Criminal Justice Services.
- In response to discussion among Council members, clarification was provided that whether jails are appropriate places to treat people with serious mental illnesses was a systemic issue beyond the scope of this agenda item. Instead, this item is focused on ensuring that such individuals received need services.

- **The Council agreed that some simple surveys should be conducted of CSBs and sheriffs to gather information about the need for services in jails.** The form in the draft Comprehensive State Plan document was discussed as a possible instrument. The surveys should be developed by a small work group. The surveys should distinguish between mental health and substance abuse services now being provided and service needs. The Commissioner indicated the sheriff's association was interested in working on this.

Update on 2002 - 2008 Comprehensive State Plan

- Charline Davidson updated the Council on the Comprehensive State Plan. She reviewed the process that has been used to develop the plan update document.

- The draft update document reflects these changes from the previous document:

    - streamlined data requirements,
    - linkage with the MR Waiver data base,
    - community need forms broken out by priority population,
    - a new average wait time table,
    - a new prevention form, and
    - separate data bases for patients and residents who are ready for discharge.

- She observed that, given the earlier discussion about jail-based services, the local jail survey in the draft plan update document may be deleted.

- As was done last time, CSBs will submit the update information in an ACCESS data base provided by the Department.

- A paper copy of the plan update forms will be distributed early next calendar year, before the ACCESS software, so that CSBs can begin gathering needed information.

- CSBs will probably begin actual data collection on April 2, 2001 and the plan update will probably be due in the Department on June 1, 2001.

Comprehensive Plan for Restructuring Virginia's Mental Health Care Programs and Facilities

- The Commissioner discussed general aspects of the effort to develop this plan, which is due to the Governor and General Assembly on December 15, 2000. The plan will probably recommend, over a period of years, moving acute inpatient psychiatric care into the community, with some small state facility capacity retained as a safety valve; retaining extended rehabilitation bed capacity in state facilities, perhaps with some small increase; and moving most geriatric care to the community using a new gero-psychiatric residential service.

- The plan is predicated on selling property and holding the proceeds in the Trust Fund.

- The first priority in the plan will be consumers, and the second priority will be state employees.

One possibility would be transferring state employees to community programs if the knowledges, skills, and abilities are matched. Consumer choice is a critical issue that must be addressed in the plan.

- In response to a question, the Commissioner suggested that CSBs raise the issue of treatment responsibility for individuals with traumatic brain injury syndrome with the Secretary. Currently serving individuals with TBI is not part of the Department's mission.

Update on Comprehensive Human Rights Information System (CHRIS) Concerns

- Paul Gilding reviewed the October 27 meeting between CSB and Department representatives.

- The Commissioner observed that implementing CHRIS requires that some judgement be used, but indicated that the definition of complaint needs to eliminate as much ambiguity as possible.

- Subsequently, the Department has issued a memorandum, dated November 8, 2000, that reiterates the contractual reporting responsibilities of CSBs and addresses some of the concerns and questions raised about CHRIS.

DMHMRSAS-DMAS Interagency Agreement

- The Commissioner distributed copies of the agreement and discussed it briefly.

- He confirmed that the Department's SPO and MR Waiver utilization review staff would be moving to DMAS, effective November 7, 2000. Consequently, field audits are on hold now.

- The Commissioner raised the vertical integration issue (care coordination/case management and services delivered by the same organization) in the context of the Care Coordination report that the Department has sent to the Secretary's Office for review. He observed that CSBs may not like his edits, which keep the door open on this issue.

- The Commissioner noted that, in the next administration, some private providers will likely try to get a piece of the public system. They are interested in networks in which CSBs would be providers. He observed that the model of an ASO managing the services system is attractive.

- The Commissioner suggested that the Care Coordination Report linkage of care coordination and case management may be a typology for the public structure, including being the recipient of resources, providing emergency services (including psychiatric services), and purchasing all other services.

New MR Waiver Development and Advisory Group Meeting

- This process is going on now.

Non-Mandated CSA Child and Adolescent Services Implementation and Funding

- The Commissioner noted that the Department has streamlined the process. Preauthorization is

no longer required, just concurrent review.

Performance Contract

- Paul Gilding reviewed the process for developing the SFY 2002 contract, noting that the emphasis for this contract would be on streamlining data and reporting requirements.

- He briefly discussed the VACSB Data Management Subcommittee, which is cataloguing all data elements and reporting requirements across the system and identifying inconsistencies and duplicative requirements. The Commissioner announced that the Department would support this project with a small amount of grant funds.

- Paul Gilding reviewed the status of requirements in the SFY 2001 performance contract that still need to be addressed. He noted that, once the definitional clarity issue regarding complaints in the Human Rights Regulation and CHRIS is resolved, the dispute resolution mechanism requirement can be addressed.

Next Meeting

- The Council's next meeting will be on December 7 at 10:00 a.m. **The Council will meet at the Hanover County CSB**. Please call Paul Gilding at 804-786-4982 if you need directions. NOTE: this is a change from the initial decision to meet in Chesapeake.

- **Tentative Agenda**

    - Review of November 1 Meeting Summary
    - Department's Technical Assistance Philosophy (further discussion about the fourth bullet on page 2 of the first meeting summary)
    - Uniform Community Clinical Care Policies and Procedures and MR Case Management Responsibility (see page 4 of this summary)
    - MR Waiver Issues, Rates, and Expenditure of the New Waiver Funds
    - Consumer Choice and Provider Access
    - Data Management
    - Performance Contract